Physiotherapy and occupational therapy and mild to moderate parkinson disease-reply

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Letters

COMMENT & RESPONSE

In Reply On behalf of the PD REHAB Collaborative Group, we are pleased that the PD REHAB Trial[1] has prompted debate. The issues raised are common to the 3 letters[2-4] and all were covered in the original article.[1]

Eligibility was based on the uncertainty principle. Investigators were mostly uncertain of the value of physiotherapy and occupational therapy in patients with mild to moderate Parkinson disease (PD). So, the results of the trial can only be applied to patients with mild to moderate disease. This is not in conflict with our Cochrane review of physical therapies in PD, which showed short-term benefits in motor function and activities of daily living but, importantly, not in quality of life in more severe disease.[5]

The Nottingham Extended Activities of Daily Living Scale was used as the primary outcome so that any benefits could be compared with those in other disease areas where it has been used before (ie, stroke and aging). It has been used in previous PD trials and correlated well with the Unified Parkinson's Disease Rating Scale activities of daily living scale in our pilot PD/OT trial.[6] This approach precluded the use of an individualized outcome as suggested by de Vries et al[4] in their letter. Although the Nottingham Extended Activities of Daily Living Scale does not directly address gait and transfers, it does assess issues such as walking outside, using public transport, and climbing stairs, which are of more practical use and more important to patients. Indeed, our patient advisory group supported the use of the Nottingham Extended Activities of Daily Living as the primary outcome for this very reason.

We too were surprised by the low dose of both therapies, but this is what is being delivered to patients with mild to moderate PD in the National Health Service (NHS) today. We do not agree with Mestriner[3] that this is nonadherence; it is a low-dose intervention. We were informed by therapists before the trial that both physiotherapists and occupational therapists see such referrals, so they wanted the combined design of the PD REHAB Trial. A large number of centers were deliberately secured to aid recruitment and to ensure that the results could be generalized across the NHS. Therefore, PD REHAB is a pragmatic trial of standard care in the NHS and not a study of a novel high-intensity form of therapy. This is the design that the funder, the NHS Health Technology Assessment Programme, wanted to inform decisions to be made about the future delivery of such services within the NHS.

The PD REHAB Trial is a high-quality, precise, adequately powered study that demonstrates that low-dose, patient-centered, goal-directed physiotherapy and occupational therapy in early PD is ineffective. We cannot ignore or seek to discredit important results that we do not find palatable. We owe it to our patients to deliver the best care possible, so future research should explore the development and testing of more structured and intensive physical and occupational therapy programs in patients with all stages of PD.

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